Out-of-Network Claim Form Instructions

IMPORTANT INFORMATION

Please read before submitting your out-of-network claim form.

1. Reimbursements are processed within **60 days** from the date we receive your out-of-network claim form.
2. Out-of-network claims for services and/or eyewear obtained from an *in-network* provider will **not** be reimbursed.

CEC understands that vision plan members may encounter sales promotions (such as "two-for-one sales") or steep discounts offered by some of our optical providers. As is true of most vision plans, your CEC vision plan is not intended for use in conjunction with these types of offers. In general, providers will allow only one of the following:

- The CEC vision benefit, or
- The sales promotion (the sale price or discount)

HOW TO FILE AN OUT-OF-NETWORK CLAIM

- Complete this form if, at the time of service, the provider did NOT participate in the CEC network.
- Complete all applicable fields on this form, including the signature. Missing information may delay processing and reimbursement.
- Submit one claim form for each patient to CEC within 180 days of the date of service.
- Submit a copy of your itemized receipt for each service or product included on this claim form.
- You have a choice of three options for submitting the completed form:

FAX	MAIL	EMAIL
(704) 413-7098	CEC Attn: Out-of-Network Claims 2359 Perimeter Pointe Parkway, Suite 150 Charlotte, NC 28208	OON@cecvision.com

CEC
community eye care

Out-of-Network Claim Form

PATIENT INFORMATION — Details of the person who received the service

Patient First and Last Name:

Patient's Relationship to Employee: ☐ Self ☐ Dependent

Patient Date of Birth:

PRIMARY MEMBER INFORMATION — Employee

Employee First and Last Name:

Employer Name:

Date of Birth:

Member ID#:

CONTACT AND MAILING INFORMATION — Where the reimbursement check should be mailed

Mailing Address:

Phone Number:

Email Address:

REQUEST FOR REIMBURSEMENT — PLEASE CHECK ALL THAT APPLY

Date of service(mm/dd/year): _____

❑ **Eye/Vision Exam** ..... Amount Paid: $ _____

Date of service (mm/dd/year): _____

❑ **Contact Lens Fit / Evaluation** Amount Paid: $ _____

COMPLETE BELOW FOR GLASSES

Date of service(mm/dd/year): _____

❑ Lenses for glasses ..... Amount Paid: $ _____

❑ Frames for glasses ..... Amount Paid: $ _____

❑ Non-prescription sunglasses ..... Amount Paid: $_____

LENS TYPE (check only one)

❑ Single Vision ❑ Bifocal ❑ Trifocal ❑ Progressive ❑ Non-prescription

COMPLETE BELOW FOR CONTACTS

❑ Date of service(mm/dd/year): _____

❑ Contact Lenses ..... Amount Paid: $_____

PROVIDER OR OPTICAL INFORMATION

Name of Provider/Optical:

Address of Provider/Optical:

Phone # of Provider/Optical:

Patient's or Authorized Person's Signature: *By signing below, I authorize the release of any medical or other information necessary to process this claim. I have read and agree to CEC's policies for out-of-network claims outlined on page one of this document.*

Signature_____ Date _____

For questions about your out-of-network reimbursement, please call 1-888-254-4290 (Option 2 and then Option 4).